B

PREMERA BLUE CROSS

Washington State Health Care Authority
Medicare Supplement Enrollment Form

SECTION 1 – APPLICANT INFORMATION

Your Social Security Number (must include) ☐☐☐-☐☐-☐☐☐☐		Spouse Social Security Number (must include) ☐☐☐-☐☐-☐☐☐☐	
Your Last Name First Name Initial		Spouse Last Name First Name Initial	
Date of Birth (month / day / year)	☐ Male ☐ Female	Spouse Date of Birth (month / day / year)	☐ Male ☐ Female
Home Address (cannot be a P.O. box)	City State Zip		
Billing Address (if different from above; not applicable to PEBB/K-12 retirees)	City State Zip		
Mailing Address (if different from above addresses)	City State Zip		
Phone Number	Medicare Supplement Plan Desired ☐ Plan E ☐ Plan J		

The Health Care Authority sets the effective date for PEBB/K-12 retirees. For all other applicants, coverage starts on the first of the month after the application postmark date, if all information is completed and accurate, and you meet the eligibility requirements in Section 2 below. To request a later effective date (no more than 90 days from postmark date), state residents should write that date here: _____/01/_____.
If you are replacing a Medicare Advantage plan, you must request to delay the effective date until after the date your Medicare Advantage coverage ends. If you need help with this, please contact us at 1-800-817-3049.

SECTION 2 – ELIGIBILITY

Public Employees Benefit Board (PEBB) and K-12 Retirees

To be eligible, you must be either an eligible PEBB or K-12 retiree or the eligible spouse of such a retiree. You must also be covered by Part A (Hospital Insurance) and Part B (Medical Insurance) of Medicare. You must enroll within one of the time limits below. Please check the time limit that applies to you. Your spouse may enroll with you even if one of the events below does not apply to your spouse.

Check one; fill in the blank if needed.

- ☐ In the 30-day period before you become eligible for Part A and B of Medicare
- ☐ Within 60 days of retirement. Retirement date: _____
- ☐ Within six months of initial enrollment in Medicare Part B
- ☐ With in six months after attaining age 65
- ☐ During an open enrollment period, if any, established by HCA for PEBB and K-12 retirees, only if you are transferring from another health plan with no lapse in coverage. Note: Existing PEBB and K-12 subscribers may change their coverage by applying for another program offered by the HCA only at the HCA's next open enrollment period for PEBB and K-12 retirees.

All Other Applicants

To be eligible, you must be a current Washington State resident. You must also be covered by Part A (Hospital Insurance) and Part B (Medical Insurance) of Medicare. You must enroll within one of the enrollment time limits below. Please check the time limit that applies to you. Your spouse may enroll with you even if one of the events below does not apply to your spouse.

If you are under 65, and your enrollment in Parts A and B of Medicare was more than six months from the date of this application, please provide a copy of your Award Notice from Social Security.

Check one; fill in the blank if needed.

- ☐ Within 60 days of establishing Washington State residency
- ☐ In the 30-day period before you become eligible for Part A and B of Medicare
- ☐ Within 60 days of retirement. Retirement date:_____
- ☐ Within six months of initial enrollment in Medicare Part B
- ☐ With in six months after attaining age 65
- ☐ During an open enrollment period, if any, established by HCA for persons who are not PEBB or K-12 retirees, only if you are transferring from another health plan with no lapse in coverage.

Additional Application Periods for All Eligible Applicants

1. You can also apply for the HCA Plan E or J if one of the two conditions below is true.

   a. You left the HCA Plan E or J to try a Medicare Advantage program (including Medicare HMO or PPO programs), PACE program, or Medicare Cost, Risk, or SELECT program for the first time. You may apply if you tried one program, more than one program of the same type, or more than one type of program. However, all four statements must be true:
   - You were covered under each program you tried for less than 12 months.
   - Each program (other than the most recent) must have been terminated voluntarily.
   - You switched programs within 63 days of the date the prior program terminated, with no other coverage in between.
   - The effective date of the last program you tried was less than 24 months after the effective date of the first program you tried.

   b. If you are applying for the HCA Plan E and J offered only to people who have Medicare by reason of age, you can also apply if, at age 65 and first becoming eligible for Medicare Part A, you enrolled in one or more PACE programs or Medicare Advantage programs (including Medicare HMO or PPO programs). All four statements in section a. must also be true.

2. You can also apply for the HCA Plan E coverage if one of the conditions below is true.

   a. You lose retiree group coverage.

   b. Your Medicare supplement coverage ended because the carrier became bankrupt or insolvent.

   c. You were covered under a Medicare Select, Medicare Advantage program, Medicare risk or cost program, or PACE program, and your coverage ended or will end for one of the folowing reasons:
   - The program was withdrawn in your area.
   - You moved away from the program's service area.
   - The carrier or agent materially misrepresented the program or materially breached its terms.

You must give us proof that you had and lost the coverage as described above. If you qualify for coverage under 1. or 2. above, you must apply no earlier than 60 days before your prior coverage is to end and no later than 63 days after that coverage ended. **Note: If you qualify under 1. above, you may only apply for the HCA Medicare supplement plan you had originally. Please complete the questions in Section 3 below.**

SECTION 3 – PRIOR COVERAGE

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance policy, or that you had certain rights to buy a policy, you may be guaranteed acceptance in one or more of our Medicare supplement plans. (See "Additional Application Periods for All Eligible Applicants" for details.) **Please answer all questions.**

To the best of your knowledge,

	You	**Spouse** (if applying)
1. a. Did you turn 65 in the last 6 months?	☐ Yes ☐ No	☐ Yes ☐ No
b. Did you enroll in Medicare Part B in the last 6 months ?	☐ Yes ☐ No	☐ Yes ☐ No

c. If yes, what is the effective date? (Please fill in on the card below.)

All applicants and their spouses, if applying, **must** fill in the boxes on the cards below with the information printed on their Medicare cards or include photocopy. We cannot process your application without this information.

You

HEALTH INSURANCE

NAME OF BENEFICIARY

MEDICARE CLAIM NUMBER

IS ENTITLED TO — EFFECTIVE DATE

Part A Hospital Insurance

Part B Medical Insurance

Spouse (if applying)

HEALTH INSURANCE

NAME OF BENEFICIARY

MEDICARE CLAIM NUMBER

IS ENTITLED TO — EFFECTIVE DATE

Part A Hospital Insurance

Part B Medical Insurance

	You	**Spouse** (if applying)
2. Medicaid is a public aid program for people with low income. It is not the same as Medicare. Are you covered for medical assistance through the state Medicaid program? Note to applicant: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer NO to this question.	☐ Yes ☐ No	☐ Yes ☐ No
a. Will Medicaid pay your premiums for this Medicare supplement coverage?	☐ Yes ☐ No	☐ Yes ☐ No
b. Do you receive any benefits from Medicaid other than payments toward your Medicare Part B premium? (**Important Note:** If you are receiving any kind of Medicaid assistance, you are not eligible to apply for this program.)	☐ Yes ☐ No	☐ Yes ☐ No
3. a. If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, a PACE plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "End" blank.	Start: _____ End: _____	Start: _____ End: _____

		You	Spouse (if applying)
b.	If you are still covered under the Medicare plan in 3.a., do you intend to replace your current coverage with this new Medicare supplement plan? (**Important Note:** If you do not intend to replace your other Medicare plan, you are not eligible to apply for this program. Your new Medicare supplement plan cannot take effect while a Medicare Advantage plan is still in force.)	☐ Yes ☐ No	☐ Yes ☐ No
c.	Was this your first time in this type of Medicare plan?	☐ Yes ☐ No	☐ Yes ☐ No
d.	Did you drop a Medicare supplement policy to enroll in the Medicare plan?	☐ Yes ☐ No	☐ Yes ☐ No
4. a.	Do you have another Medicare supplement policy or certificate in force?	☐ Yes ☐ No	☐ Yes ☐ No
b.	If so, with which company and what plan do you have? Company	_____	_____
	Plan (A, B, C etc.)	_____	_____
c.	If so, do you intend to replace your current Medicare supplement policy with this coverage? (Important Note: If you do not intend to replace all other Medicare supplement coverage, you are not eligible to apply for this program.)	☐ Yes ☐ No	☐ Yes ☐ No
5.	Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan.)	☐ Yes ☐ No	☐ Yes ☐ No
a.	If so, with which company and what kind of policy? Company	_____	_____
	Type of Policy	_____	_____
b.	What are your dates of coverage under the other policy? (If you are still covered under the other policy, leave "End" blank.)	Start: _____	Start: _____
		End: _____	End: _____

SECTION 4 – INFORMATION YOU NEED TO KNOW

A. You do not need more than one Medicare supplement contract.
B. If you purchase this coverage, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
C. If you are 65 or older, you may be eligible for benefits under Medicaid and may not need a Medicare supplement contract.

D. If, after purchasing this plan, you become entitled to Medicaid, the benefits and premiums under your Medicare supplement contract can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare Supplement plan (or, if that is no longer available, a substantially equivalent plan) will be reinstituted if requested within 90 days of losing Medicaid eligibility. If the Medicare supplement plan provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your plan was suspended, the reinstituted plan will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

E. If you are eligible for and have enrolled in a Medicare supplement plan by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement plan can be suspended, if requested, while you are covered under the employer or union-based group health benefit plan. If you suspend your Medicare supplement plan under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement plan (or, if that is no longer available, a substantially equivalent plan) will be reinstituted if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

F. Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement coverage and concerning medical assistance through the state Medicaid program, including benefits as a "Qualified Medicare Beneficiary" (Q.M.B.) and a "Specified Low-Income Medicare Beneficiary" (S.L.M.B.).

G. Did you receive a copy of the Outline of Coverage? ☐ Yes ☐ No

H. Would you like to receive a copy of Medicare's "Choosing a Medigap Policy" guide? ☐ Yes ☐ No

SECTION 5 – BILLING

(STATE RESIDENTS ONLY -- DOES NOT APPLY TO PEBB OR K-12 RETIREES)

Please indicate your desired payment option (please do not send a payment at this time):

☐ Monthly Billing
☐ Monthly Automatic Funds Transfer (A.F.T.)

If you select the A.F.T. payment option you must sign and date the enclosed Automatic Funds Transfer Authorization form, and include a deposit slip or voided check.

SECTION 6 – SIGNATURE

I hereby apply for the Premera Blue Cross Group Medicare Supplement Plan, and agree to the terms of the contract offered. I understand that I must meet the applicable eligibility requirements and apply within the time limits that are shown below on this form. ☐ **Yes** ☐ **No**. I understand that Premera Blue Cross may collect, use, and disclose personal information about me as required or permitted by law to perform routine business functions, such as determining my eligibility for enrollment and benefits; paying claims; and fulfilling other obligations stated in its contract with the Health Care Authority. If Premera Blue Cross discloses my personal information for any other reason, Premera Blue Cross will first remove any data that can be used to easily identify me or will get my signed authorization. I certify that the foregoing statements and answers are complete and true, and I understand that all rights to payment of medical claims by Premera Blue Cross are void if any statement made by me herein is found to be false or incomplete.

X Be sure to sign after printing _____ X Be sure to sign after printing _____

Applicant Signature Date Spouse Signature Date

CHECK LIST

To help us process your application faster, please take a moment to make sure that you have completed the following steps before you send your application.

1. You must be enrolled (or have proof of enrollment) in both Medicare Part A (Hospital Insurance) and Part B (Medical Insurance).
2. Fill in the sample Medicare card with the information on your own Medicare card or provide a copy of your Medicare card. We cannot process your application without your Medicare information.
3. You must answer all enrollment questions to the best of your knowledge.
4. Sign the application.
5. Include a copy of the certificate of coverage from prior insurer if needed to confirm prior coverage. If you are under 65, please include a copy of your Award Notice if needed (see section 2).